Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 30, 2014	2014_157210_0014	T-562-14, T-115-14, T-568-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

Long-Term Care Home/Foyer de soins de longue durée

WESTSIDE
1145 Albion Road, Rexdale, ON, M9V-4J7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 19, 20, 21, 2014.

Non compliance found during this inspection in relation to LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights is being issued under of T-115-14 conducted concurently with this inspection.

During the course of the inspection, the inspector(s) spoke with registered nurses (RN), registered practical nurse (RPN), RAI MDS Coordinator, personal support worker (PSW), director of care (DOC).

During the course of the inspection, the inspector(s) interviewed residents, reviewed clinical records, observed the provision of care.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care

Specifically failed to comply with the following:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the initial plan of care is developed within 21 days of the admission.

Review of the clinical record indicated resident #13 was admitted in the home in the first quarter of 2014. The following sections of the written plan of care were developed consequently: recreation and leisure activities, nutritional risk, and bed mobility, transfer, mobility, eating, toileting, hygiene/grooming, oral hygiene, showers two months after the admission.

Interview with RAI MDS coordinator confirmed that a 24 hours care plan was created within 24 hours of admission for the resident but not the complete written plan of care within 21 days of admission. [s. 25. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Interview with an identified PSW and a registered nursing staff indicated that the resident is not able to talk clearly but is able to call staff when wanted to go to bed and that is usually after dinner. An identified staff stated that the usual time when the staff would assist the resident going to bed was between 7:00-8:00 p.m. and three times a week right after dinner (5:00 p.m.). Further, another identified staff stated that the resident is not assisted going to bed always right after dinner because the staff is going for break in that time-period or the resident is going for activities and the resident is still calling for some kind of help if in bed right after dinner.

Review of the written plan of care did not include a section for sleep patterns and preferences. Interview with the registered nursing staff confirmed the resident's sleep patterns and preferences were not assessed by the interdisciplinary team. [s. 26. (3) 21.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. Review of the clinical record for resident #1 indicated the responsive behaviors have not been identified, strategies developed and actions are taken to respond to the needs of the resident in the period of at least two months since admission.

Review of the admission documents (2014) from CCAC indicated the following: "… the client prefers to stay in bed and on most days, needs repeated encouragements to change posture or to sit for meals and snacks. There are days when his/her mood is improved and he/she is cooperative and easier going with instructions. He/she resists by way of saying "no" tightening up his/her body, and trying to move his/her unaffected arm towards the worker on occasion. There has been two occasions when made motions to attempt to scratch staff's neck area but the staff prevented any potential by holding his/her arm. He/she has hemiparesis in one affected arm/hand so he/she lacks the strength/ability to inflict harm onto others. The worker is cautious and when he/she is presenting as resistant, to ensure care giver's safety he/she holds his/her hand when in his/her immediate personal space. Strategies that have been successful are gentle encouragement, explaining the need to sit and change his/her posture and saying that "I will tell your spouse".

Interview with an identified staff indicated several months after the admission, the resident kicked an identified staff to his/her leg, while applying the foot rest on his/her wheelchair. Review of the clinical record indicated, one month after the initial incident, the resident scratched another identified staff on the right side of the neck when he/she was about to be transferred from the wheelchair to the bed and asked staff to be toileted.

Record review and staff interview confirmed that there was no plan of care in place for the resident related to responsive behaviors including appropriate strategies developed and implemented to respond to his/her behaviors at the admission and three months after. [s. 53. (4)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually.

Review of the staff training records on abuse recognition and prevention indicated 20% staff did not receive training in 2013.

Interview with DOC confirmed that not all staff who provide direct care to residents received training relating to abuse recognition and prevention in 2013. [s. 221. (2)]

Issued on this 16th day of October, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs